

COMMONWEALTH OF MASSACHUSETTS
HEALTH POLICY COMMISSION

Improving Healthcare Quality and Controlling Costs:
Lessons from Massachusetts

Connecticut Legislative Roundtable
February 26, 2015



The Massachusetts story

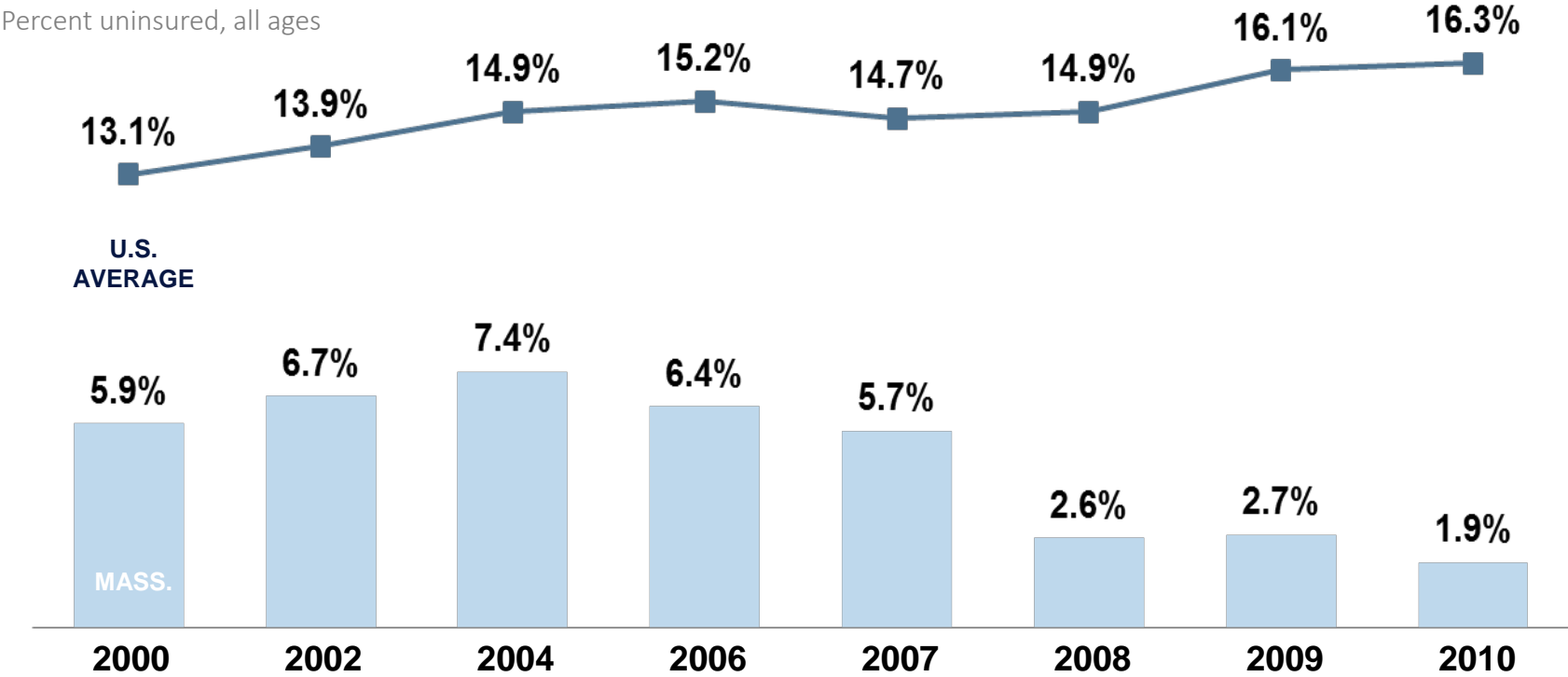
Health Care Reform Part I

Chapter 58 Bill Signing, Faneuil Hall, Boston, April 2006



The Massachusetts story

Massachusetts now has the lowest rate of uninsurance



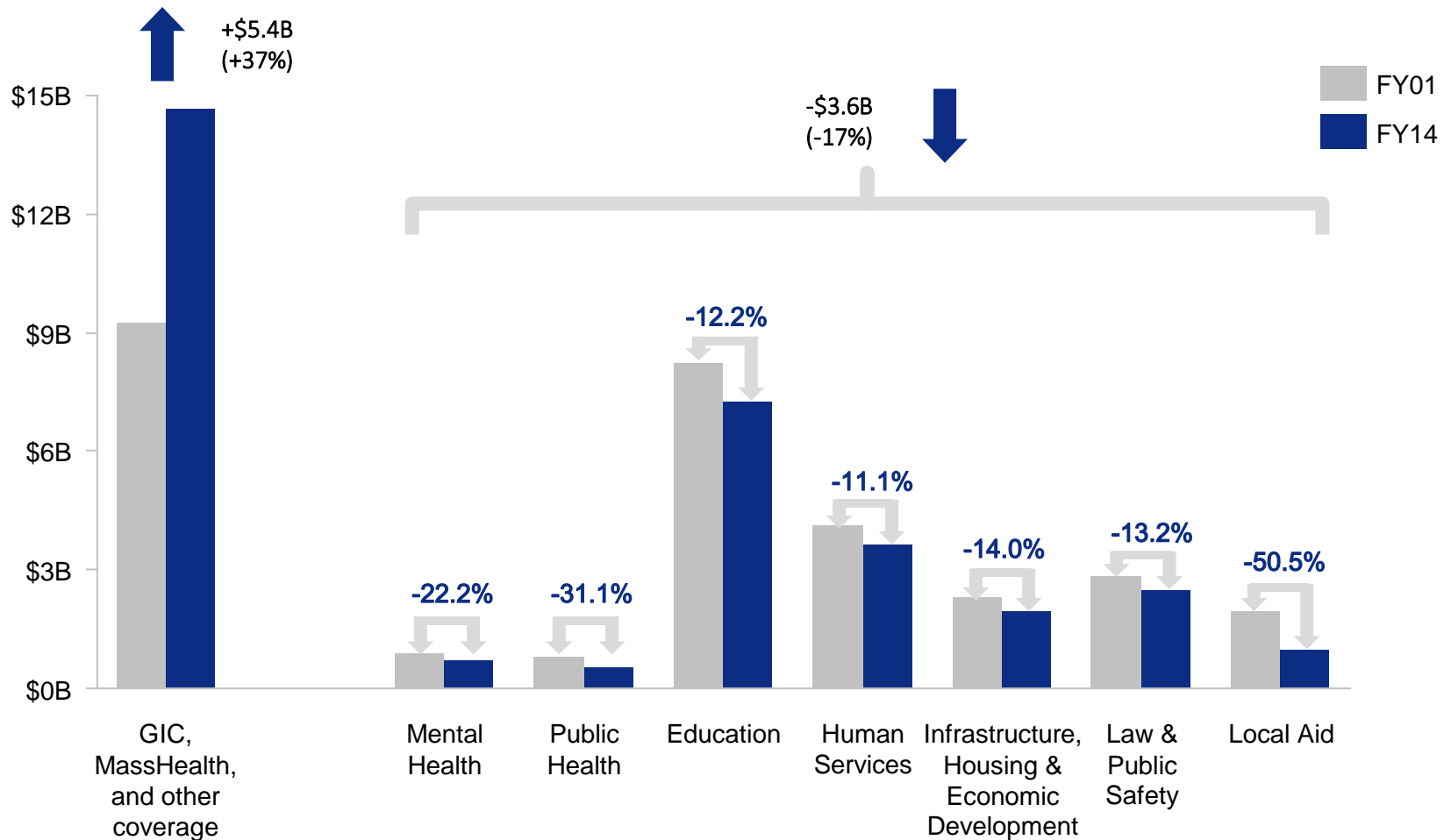
NOTE: The Massachusetts specific results are from a state-funded survey — the Massachusetts Health Insurance Survey (MHIS). Using a different methodology, researchers at the Urban Institute estimated that 507,000 Massachusetts residents were uninsured in 2005, or approximately 8.1 percent of the total population. Starting in 2008, the MHIS sampling methodology and survey questionnaire were enhanced. These changes may affect comparability of the 2008 and later results to prior years. The national comparison presented here utilizes a different survey methodology, the Current Population Survey, which is known to undercount Medicaid enrollment in some states.

SOURCES: Urban Institute, Health Insurance Coverage and the Uninsured in Massachusetts: An Update Based on 2005 Current Population Survey Data In Massachusetts, 2007; Massachusetts Division of Health Care Finance and Policy, Massachusetts Health Insurance Survey 2000, 2002, 2004, 2006, 2007, 2008, 2009, 2010; U.S. Census Bureau, Current Population Survey 2010.

The Massachusetts story

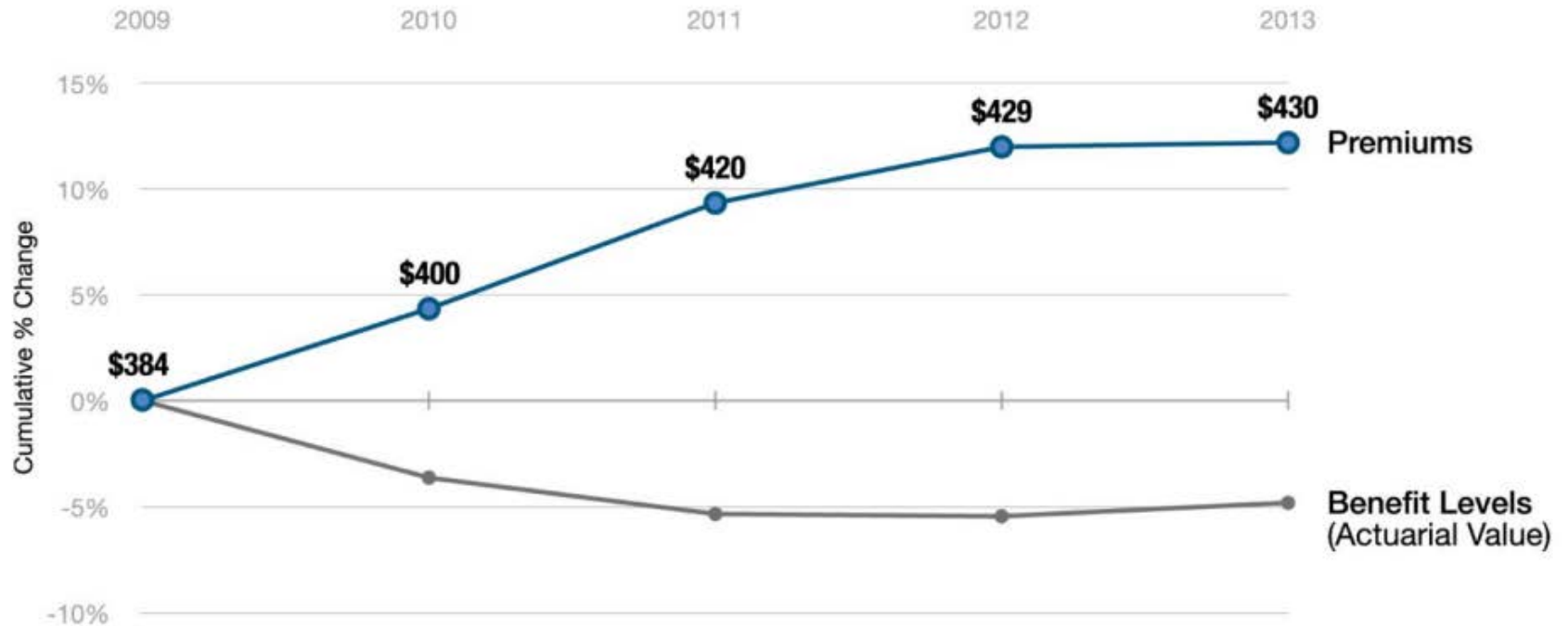
Massachusetts State Budget Comparison, FY2001 and FY2014

Billions of dollars



The Massachusetts story

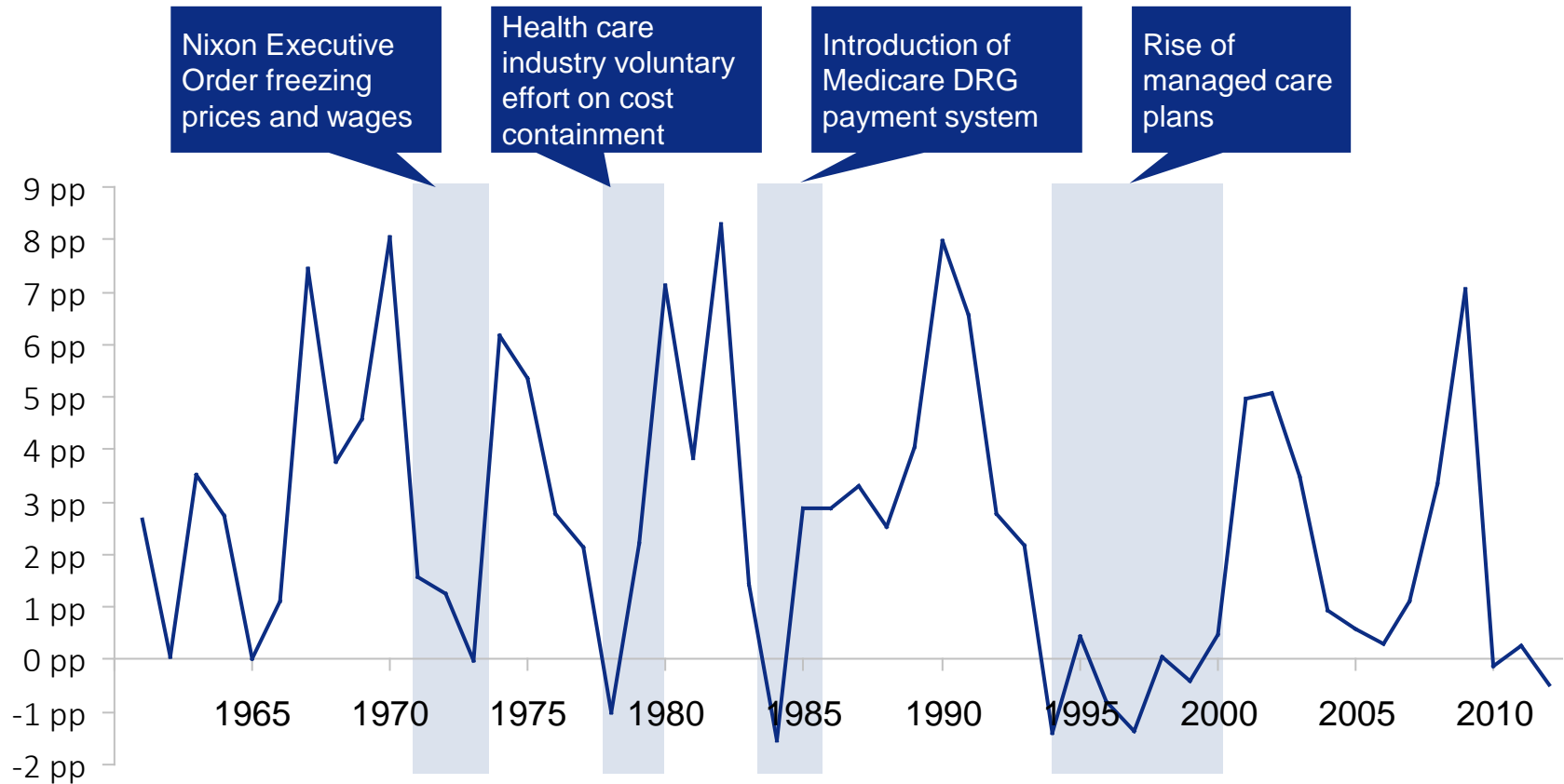
From 2009 to 2012 premiums were rising while benefit levels were falling



The Massachusetts story

U.S. growth in personal health care expenditures in excess of economic growth*

Percentage points of health care expenditure growth minus GDP growth



* Personal health care expenditures (PHC) are a subset of national health expenditures. PHC excludes administration and the net cost of private insurance, public health activity, and investment in research, structures and equipment.

The Massachusetts story

Insurance Reforms
Community Rating,
Guaranteed Coverage

1990s

Ch. 58 Passed
Health care reform

2006

Ch. 305 Passed
Health care
transparency and
e-Health

2008

Ch. 288 Passed
Small business
health care relief

2010

Ch. 224 Passed
Health care cost
containment

2012

The Massachusetts story

Health Care Reform II

Chapter 224 of the Acts of 2012, an Act Improving the Quality of Health Care and Reducing Costs Through Increased Transparency, Efficiency and Innovation, was signed into law on August 4, 2012 by Governor Patrick and became effective on November 5, 2012.



Health care cost growth benchmark

- Sets a target for controlling the growth of total health care expenditures:
 - Annual increase in total health care spending not to exceed economic growth through 2017, growth minus 0.5% for next 5 years, then back to the base growth rate
 - Economic growth rate in 2013, 2014, and 2015 equals 3.6%
- If target is not met, the Health Policy Commission can require health care entities to implement Performance Improvement Plans and submit to strict monitoring

CALENDAR YEARS	COST GROWTH BENCHMARK
2013-2017	Equal to the Economic Growth Rate
2018-2022	Equal to the Economic Growth Rate minus 0.5% (may be modified by the HPC)
2023 and beyond	Equal to the Economic Growth Rate (may be modified by the HPC)

TOTAL HEALTH CARE EXPENDITURES

- **Definition:** Annual per capita sum of all health care expenditures in the Commonwealth from public and private sources
- **Includes**
 - All categories of medical expenses and all non-claims related payments to providers
 - All patient cost-sharing amounts, such as deductibles and copayments
 - Net cost of private health insurance



A more holistic measure of health care expenditure growth than just total medical expenditures

Vision of Massachusetts cost containment reform law

- 1 Transforming the way we deliver care
- 2 Reforming the way we pay for care
- 3 Developing a value-based health care market
- 4 Engaging purchasers through information and incentives

**A more transparent,
accountable health care
system that ensures
quality, affordable health
care for Massachusetts
residents**

Key provisions of chapter 224

- Sets a benchmark to reduce future health care cost growth to the growth in the state's overall economy.
- Promotes payment system reform by both public and private payers.
- Promotes delivery system reform to enhance the coordination of care for patients.
- Promotes prevention and wellness, including the expanded adoption of workplace wellness programs through a small business tax credit.
- Invests in the expansion of a statewide, interoperable electronic health record system for all providers.
- Increases scrutiny of health care market power and price variation.
- Supports expansion of the primary care workforce and provides key resources for workforce development and training programs.
- Provides consumers and employers with quality and cost data to inform decision-making.
- Promotes administrative efficiency.

New implementing state agencies

CHIA



HPC

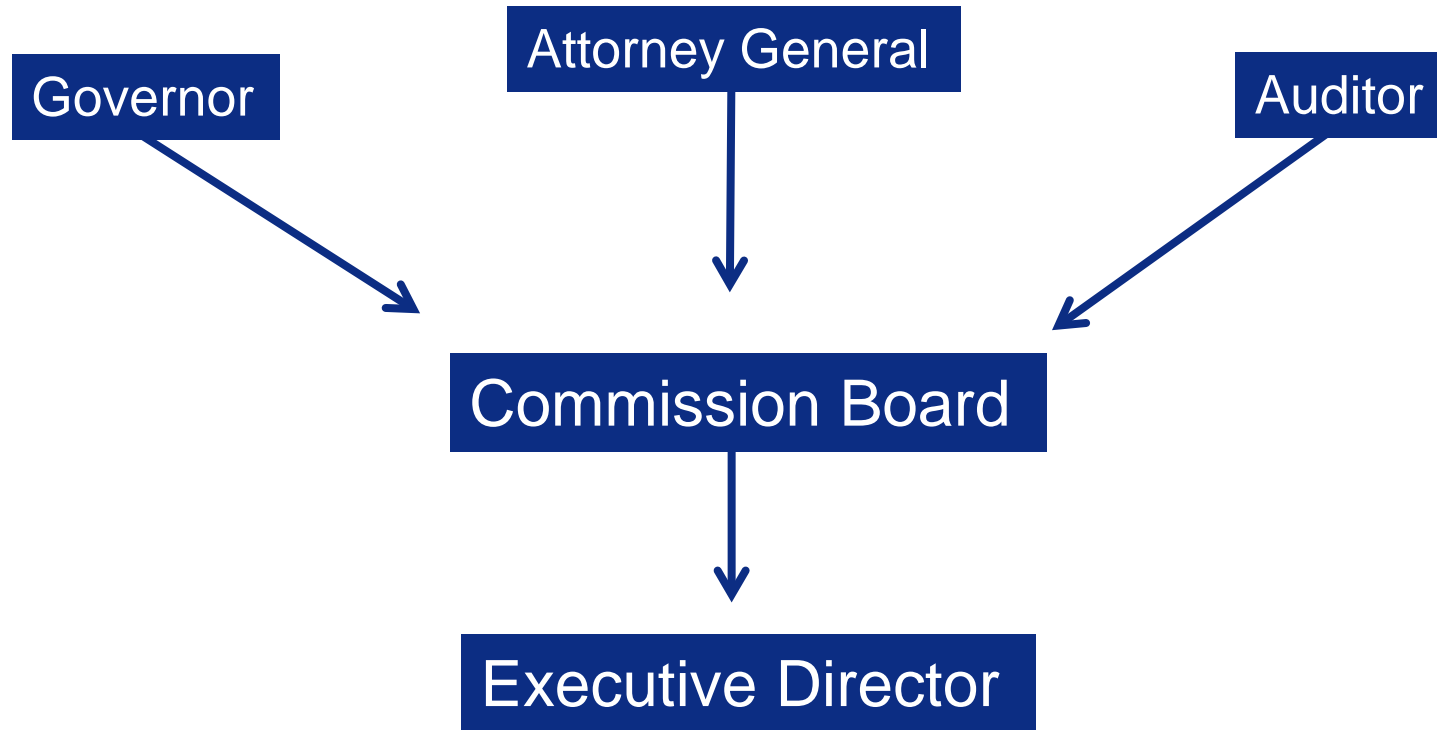
Center for Health Information and Analysis (CHIA)

- Data and analytics hub
- Independent state agency led by an Executive Director appointed by Governor, Auditor, and the Attorney General
- Duties include:
 - Collects and reports a wide variety of provider and health plan data
 - Examines trends in the commercial health care market, including changes in premiums and benefit levels, market concentration, and spending and retention
 - Manages the All Payer Claims Database
 - Maintains consumer-facing cost transparency website, MyHealthCareOptions

Health Policy Commission (HPC)

- Policy development hub
- Independent state agency governed by an 11-member board with diverse experience in health care
- Duties include:
 - Sets statewide health care cost growth benchmark
 - Enforces performance against the benchmark
 - Certifies accountable care organizations and patient-centered medical homes
 - Registers provider organizations
 - Conducts cost and market impact reviews
 - Holds annual cost trend hearings
 - Produces annual cost trends report
 - Support investments in community hospitals

Who we are



MISSION: To monitor the reform of the health care delivery and payment systems in Massachusetts and develop health policy to reduce overall cost growth while improving the quality of patient care.

Our approach

- **Collaborate** with stakeholders and all interested constituencies in the development of policy.
- **Engage** experts, both within and outside the health care industry.
- **Encourage** innovation without a “one-size fits all approach”.
- **Coordinate** with other local, state, and federal initiatives.
- **Minimize** administrative burden and duplication while maximizing the use of existing resources, including data and information.
- **Promote** public transparency and accountability in all activities of the HPC.

Ongoing HPC Responsibilities

- Monitor system transformation in the Commonwealth and cost drivers therein
- Make investments in the Commonwealth's community hospitals to establish the foundation necessary for sustainable system transformation
- Promote an efficient, high-quality health care delivery system in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status
- Examine significant changes in the health care marketplace and their potential impact on cost, quality, access, and market competitiveness



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Legislative mandate for HPC's annual cost trends report

Section 8g of Chapter 224 of the Acts of 2012

The commission shall compile an **annual report concerning spending trends and underlying factors**, along with any **recommendations for strategies to increase the efficiency of the health care system**. The report shall be based on the commission's analysis of information provided at the **hearings** by providers, provider organizations and insurers, **registration data** collected under section 11, **data collected by the Center for Health Information and Analysis** under sections 8, 9 and 10 of chapter 12C and **any other information the commission considers necessary to fulfill its duties under this section**, as further defined in regulations promulgated by the commission. The report shall be submitted to the chairs of the house and senate committees on ways and means and the chairs of the joint committee on health care financing and shall be published and available to the public not later than December 31 of each year. The report shall include **any legislative language necessary to implement the recommendations**.

Required outputs

- **Annual report concerning spending trends and underlying factors**
- **Recommendations for strategies to increase efficiency**
- **Legislative language necessary to implement recommendations**

Data inputs

- **Hearings**
- **Registration data**
- **CHIA data**
- **Any other information necessary to fulfill duties**

Spending trends

Previous findings

- Over the past decade, Massachusetts health care spending grew faster than the national average, driven by faster growth in commercial prices.
- By 2009, spending per capita was 36% higher than the national average, making Massachusetts the highest in the U.S.

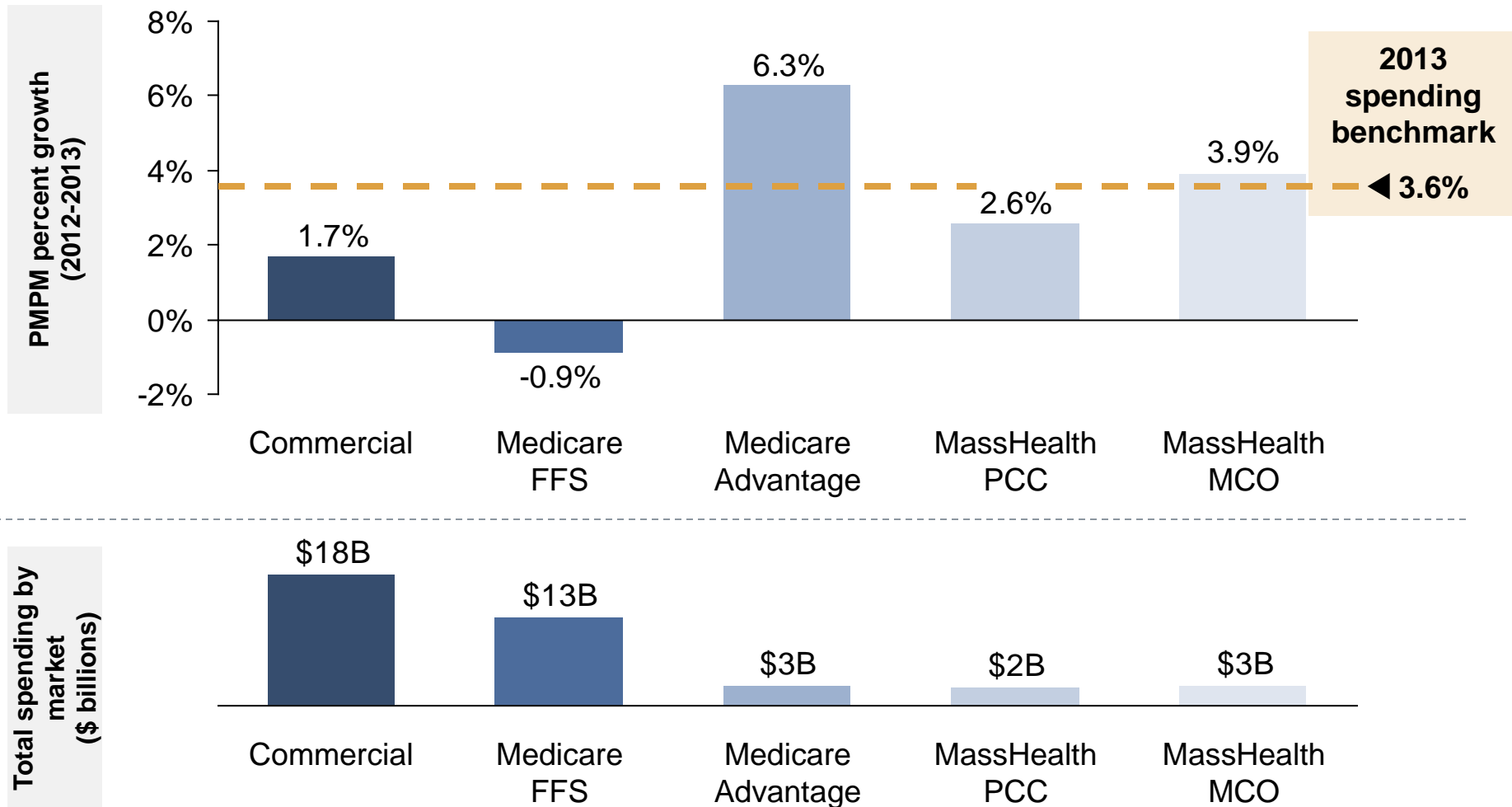
The HPC set the 2013 target growth rate in per-capita health care spending at 3.6%.

New findings

- Growth in 2013 was 2.3%, below the 3.6% benchmark.
- Low growth in 2013 may be part of an ongoing trend.
 - All payer categories have grown more slowly than the U.S. since 2011.
 - If Massachusetts had grown at U.S. rates between 2009 and 2013, spending would have been roughly ~\$900 million higher in 2013.
- Massachusetts may be able to maintain low spending growth, but future trends are uncertain.

Spending growth between 2012 and 2013 was below the benchmark for most payers

Per-enrollee annual percent growth (%), 2012-2013, and total spending by market (\$ billions), 2013



Delivery system trends

Previous findings

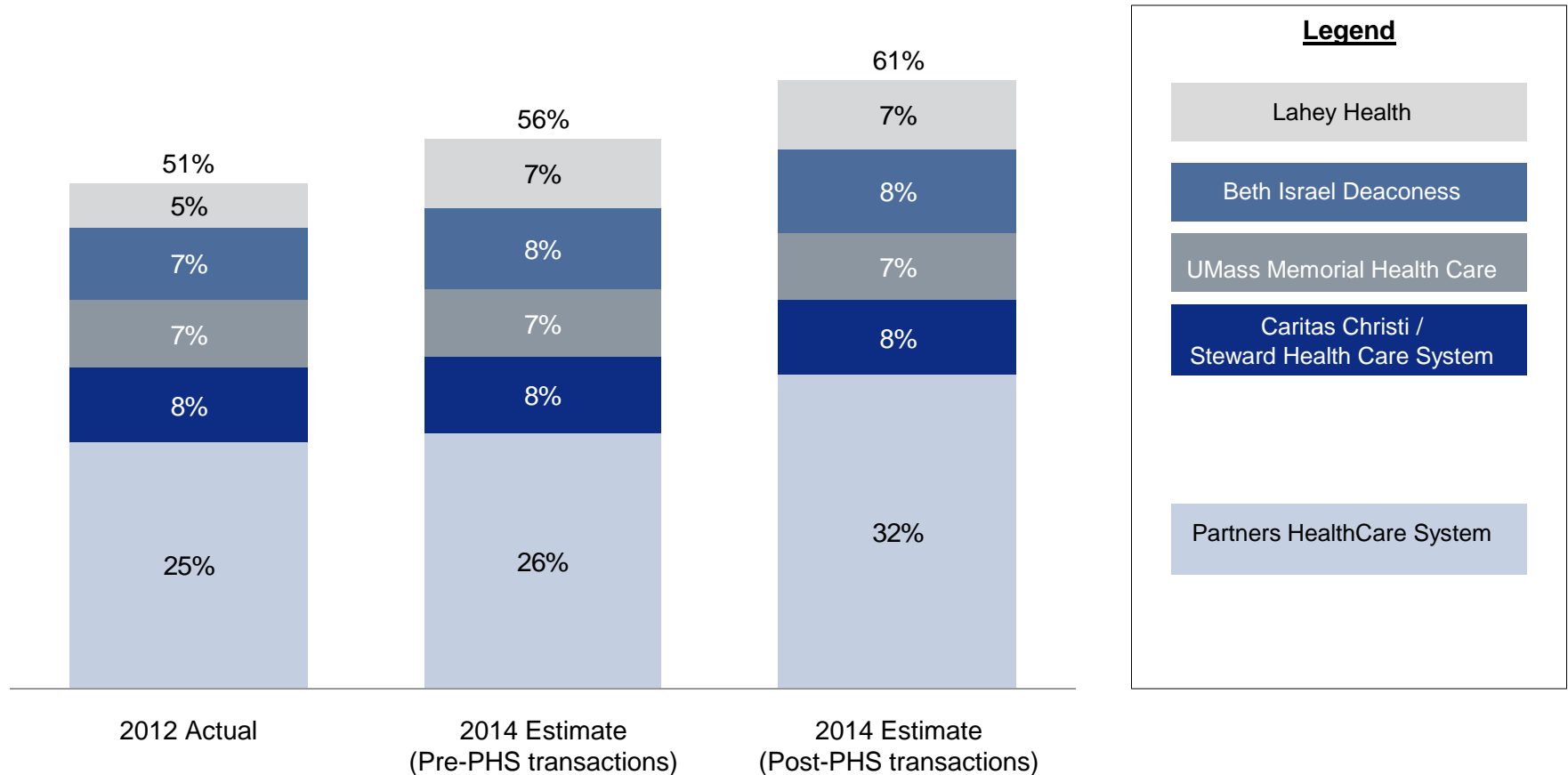
- Health care delivered in Massachusetts is increasingly concentrated in large systems.
- The percentage of inpatient discharges from the top five hospital systems increased between 2009 and 2012.

New findings

- The percentage of inpatient discharges from the top five hospital systems increased further between 2009 and 2014.
- The percentage of inpatient discharges from independent (non-AMC-affiliated) community hospitals decreased from 29 percent to an estimated 17 percent between 2009 and 2014.
- Occupancy rates at community hospitals are at approximately 60%, well below those at other hospitals (~75-85%).

A growing percentage of inpatient discharges occur in hospitals that are part of large systems, with potential implications for cost, quality and access

Percentage of total inpatient discharges



Note: 2014 data not yet available. PHS = Partners HealthCare System. Pre-PHS transactions are based on applying systems established by 2014 (including 2013 Partners HealthCare acquisition of Cooley Dickinson and 2014 Lahey Health acquisition of Winchester hospital) to 2012 inpatient discharge data. Post-PHS transactions estimate includes South Shore Hospital and Hallmark Health hospitals joining Partners HealthCare System. Figures may not add to totals due to rounding.

Source: Center for Health Information and Analysis; HPC analysis

Provider variation – spending per episode

Motivation for studying

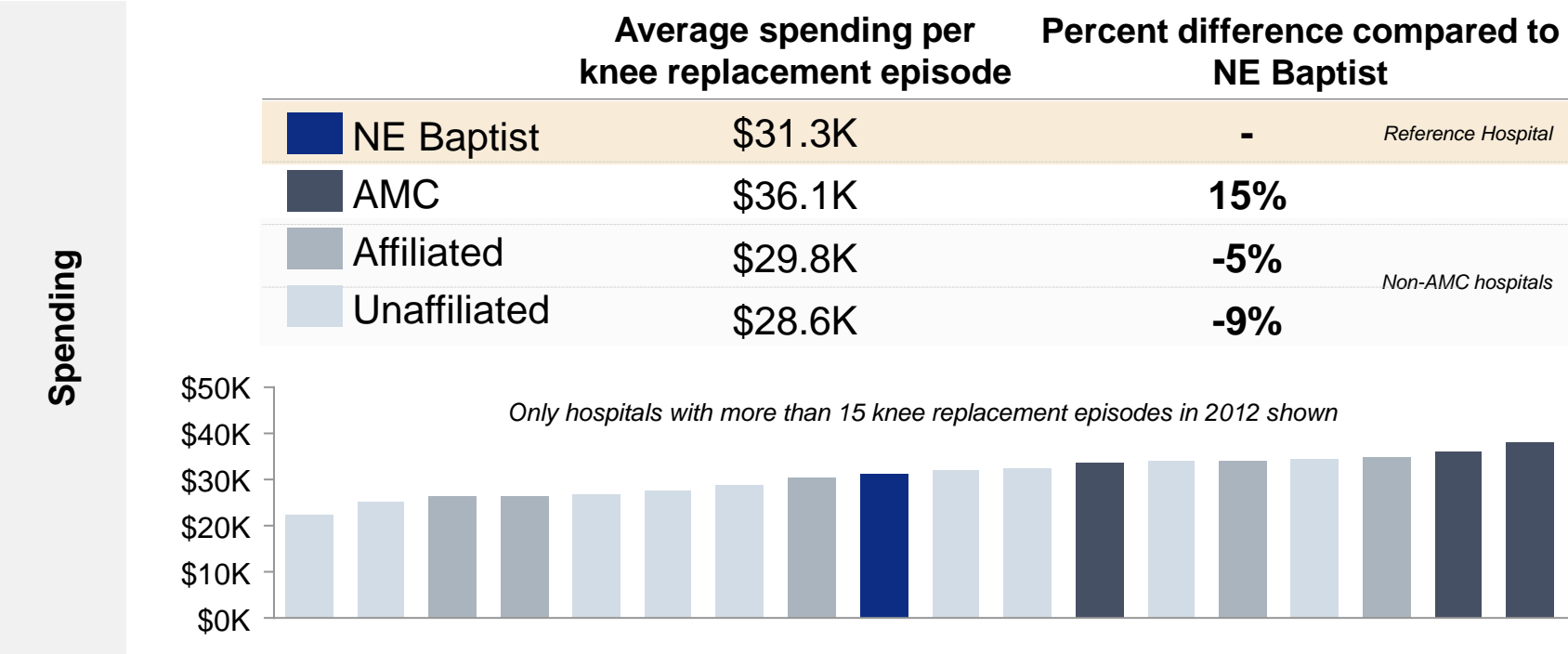
- Episodes of care cover related spending before and after a procedure.
- Studies of provider practice variation highlight possible opportunities to improve care and/or contain costs.
- Analyzing episodes goes beyond studies of hospital prices to examine spending measures that cross settings.

New findings in 2014 Report

- For three common conditions (knee replacement, hip replacement, percutaneous coronary intervention in a low-risk commercial population), hospitals vary widely in health spending across an episode of care, without measurable differences in quality.
 - For each condition, we compared spending at academic medical centers against a benchmark or benchmark group.

Total spending for low-severity knee replacement commercial episodes varies by hospital type, with little relationship to quality

Average total spending per episode of knee replacement, by hospital*



Quality

- Almost all hospitals had **readmissions** and **complications rates no different statistically** from the U.S. average
- Only New England Baptist had statistically better rates, but the difference was small

*Only hospitals with greater than 15 discharges are displayed as bars; average payment shown in table includes all hospitals studied
Source: HPC Analysis of All-Payer Claims Database, 2012

Post-acute care

Previous findings from 2013 Report & 2014 Supplement

- In 2011, Massachusetts hospitals were 2.1 times as likely as the national average to discharge patients to post-acute care, adjusting for patient characteristics, clinical conditions, and length of stay.

New findings in 2014 Report

- Wide variation exists in discharge practice patterns among Massachusetts hospitals, both in total discharge to post-acute care and the balance between home health and institutional settings (SNF, IRF, LTCH).
- While “right” level of use is not clear, higher use of institutional settings shows need for focus on optimizing care delivery.

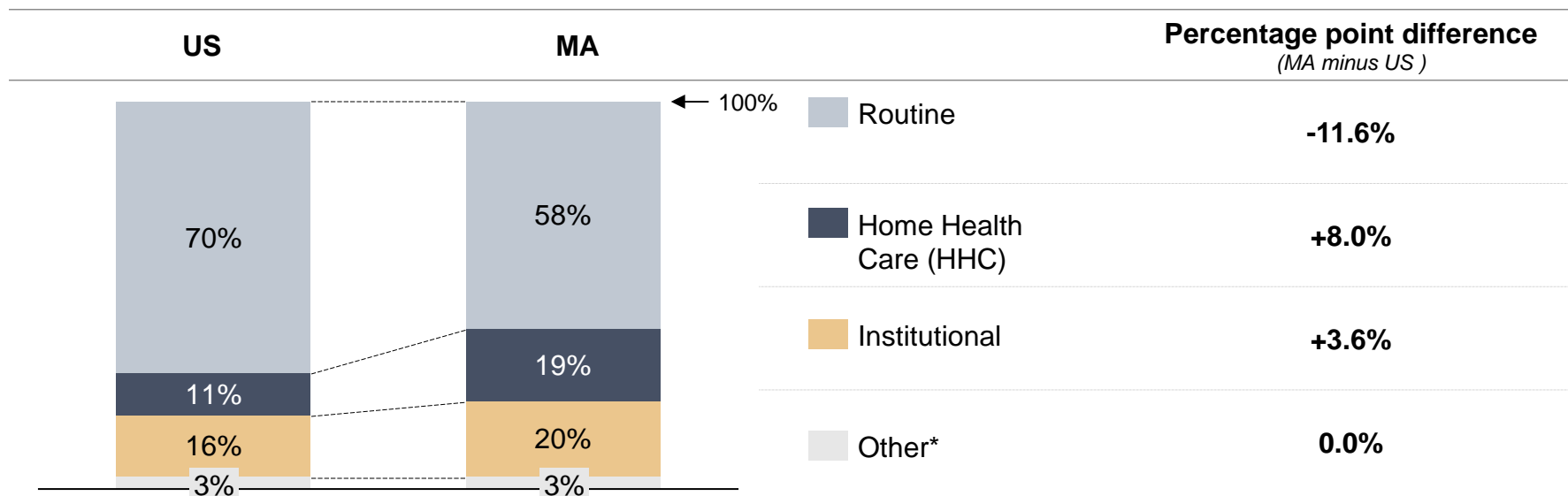
Relative to nation, Massachusetts has higher rates of discharge to home health and to institutional settings

Post-acute care

- MA has higher rates of discharge to home health and to institutional settings (skilled nursing facilities, inpatient rehabilitation facilities, and long-term care hospitals)
- Rates of readmissions and complications are similar in MA and the US

MASSACHUSETTS AND U.S. DISCHARGE DESTINATION

For all payers, for all discharges, 2011



The difference in Medicare spending in MA if MA had the same post-acute care use as in the U.S. overall could total almost **\$400 million a year**

*Other includes Against Medical Advice (AMA); died; alive destination unknown; and not recorded.

Note: Institutional includes Skilled Nursing Facility (SNF); Short-term hospital; Intermediate Care Facility (ICF); and Another Type of Facility.

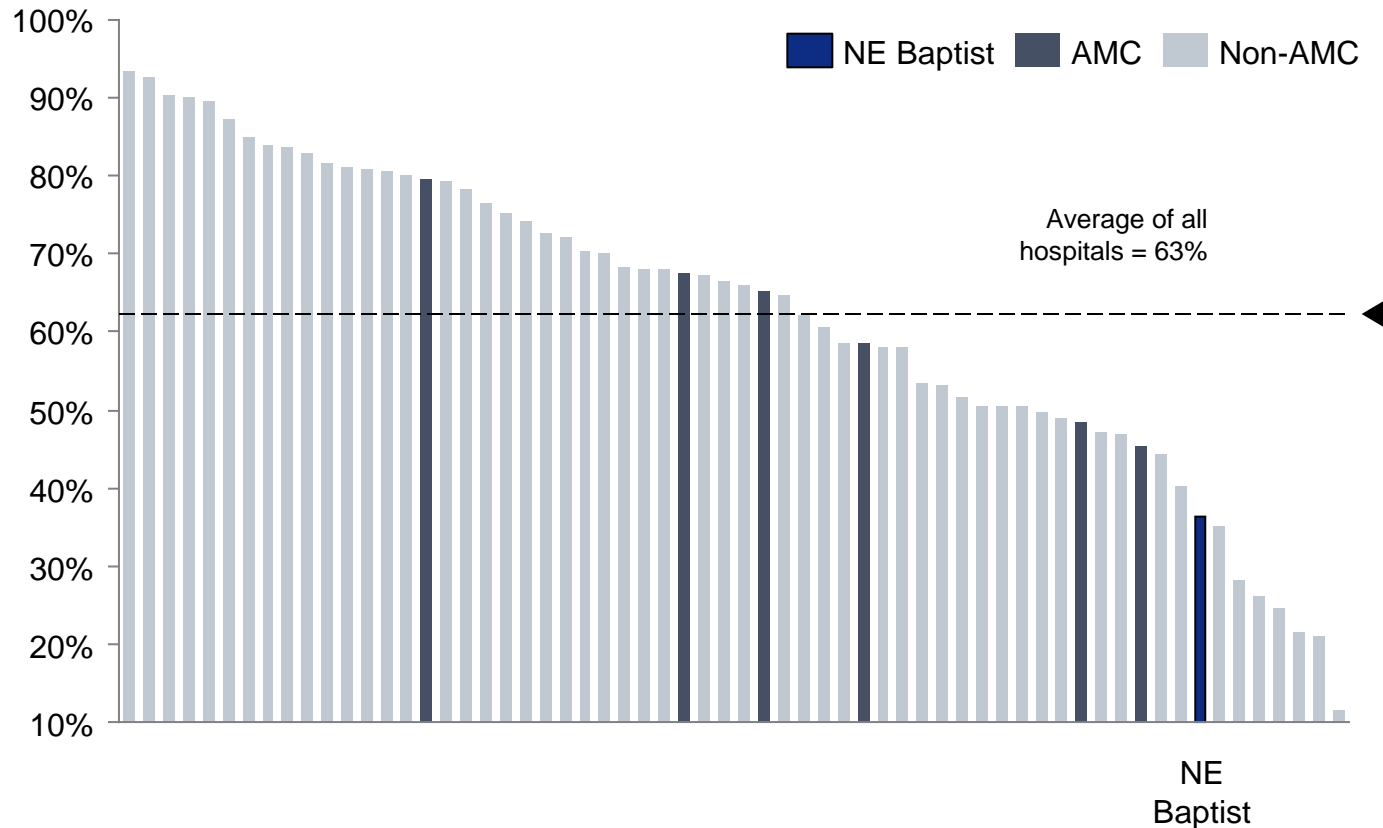
Institutional: includes skilled nursing facility, short-term hospital, intermediate care facility, another type of facility including inpatient rehabilitation facility and long-term care hospital.

Source: HPC analysis of HCUP

Within Massachusetts, for joint replacement, the percentage of patients discharged to institutional settings varies widely

Post-acute care

Share of all post-acute care discharges sent to an institutional setting for DRG 470 (major joint replacement w/o MCC), 2012



Note: Probabilities for each hospital were calculated after adjusting for the following: age, sex, payer group, income, admit source of the patient, and length of stay. Our sample only all discharged patients that were at least 18 years of age, and had either a discharge to a long-term acute care hospital, inpatient rehabilitation facility, skilled nursing facility, or a discharge to a home healthcare provider. Specialty hospitals, except for New England Baptist, were excluded from the display table and in calculating the Adjusted State Rate. "Non-AMC" pertains to community hospitals and major teaching hospitals. "AMC" pertains to those hospitals defined as Academic Medical Centers, based on the Center for Health Information and Analysis' Acute Cohort Hospital Profiles.

Source: HPC analysis of Massachusetts Health Data Consortium inpatient discharge data, 2012

Wasteful spending

Previous findings from 2013 Report & 2014 Supplement

- An estimated 21 to 39 percent of healthcare spending in Massachusetts can be considered wasteful

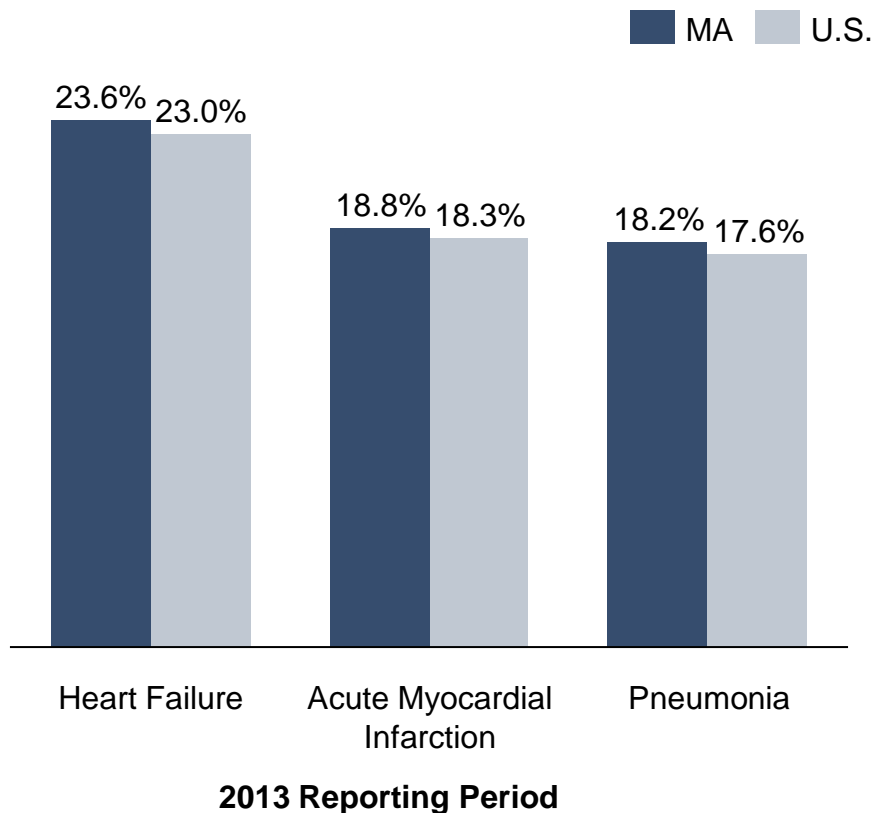
New findings in 2014 Report

- Measures of readmissions and avoidable emergency department (ED) visits continue to highlight areas for improvement in care delivery throughout the system.
- Massachusetts compares poorly to the U.S. overall on readmission rates.
- Almost half of ED visits in Massachusetts were preventable in 2012.

Massachusetts compares poorly to the U.S. overall on Medicare readmission rates

Waste

Risk-adjusted readmission rates, 2013 CMS reporting period



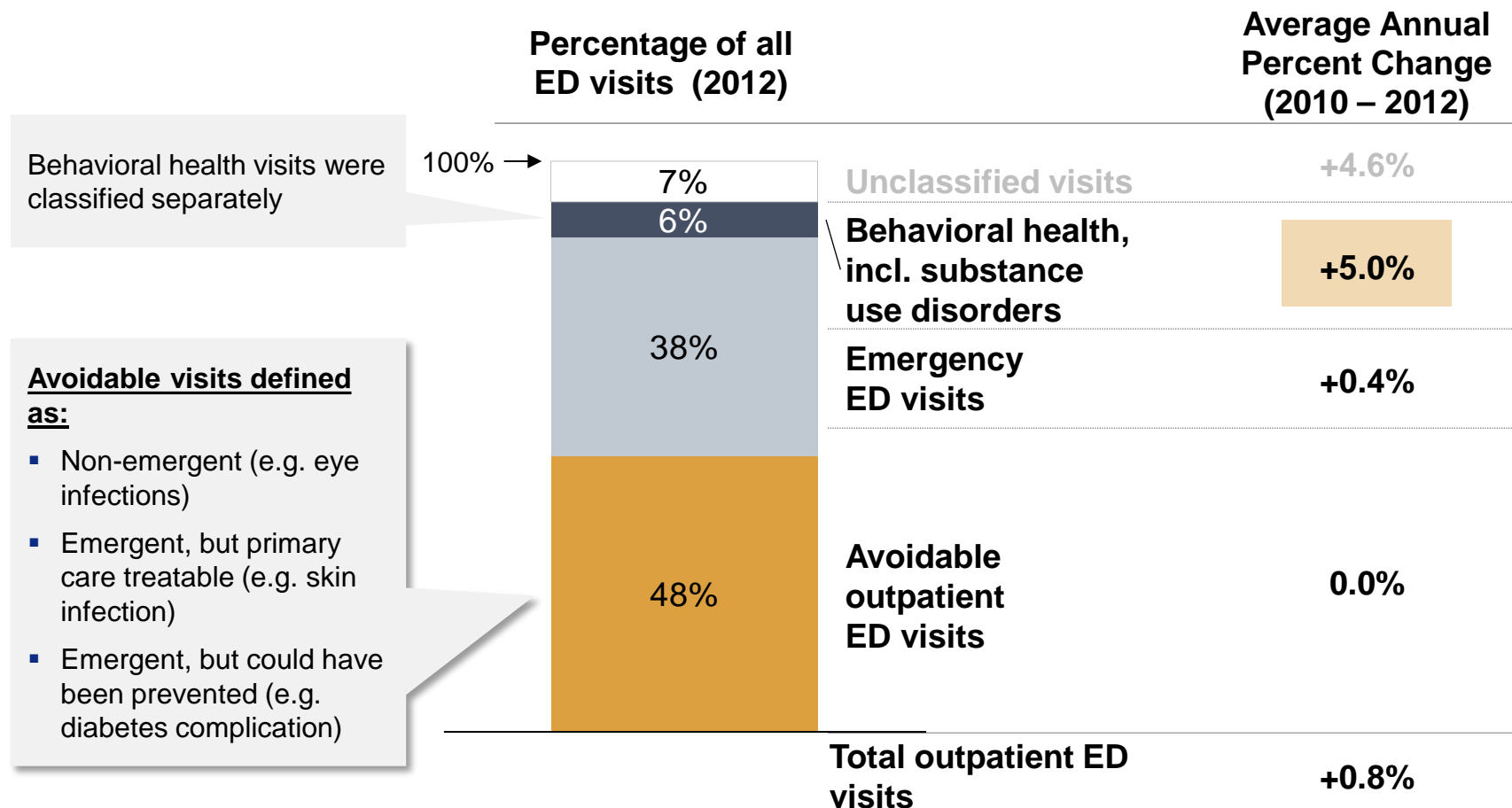
- MA ranks 46 out of 50 states and D.C. on readmission rates
- 80 percent of MA hospitals face CMS readmission penalties this year
- MA has the 8th highest average penalty in the U.S.
 - Average 0.8 percent cut to payments for all Medicare discharges

Note: These 30-day unplanned readmission measures adjust for patient characteristics, including the patient's age, past medical history, and comorbidities.

Source: Centers for Medicare & Medicaid Services, Hospital Compare 2013

Avoidable ED visits make up about half of all ED visits in MA

Waste



Share of all ED visits considered avoidable was fairly constant across all MA regions, ranging from 46 percent to 52 percent

Note: Definition for avoidable ED visits based on NYU Billings Algorithm

Source: NYU Center for Health and Public Service Research; HPC analysis of Centers for Health Information and Analysis outpatient ED database, FY2010-FY2012

High-cost patients

Previous findings from 2013 Report & 2014 Supplement

- Five percent of commercial patients account for 45 percent of total commercial medical spending.

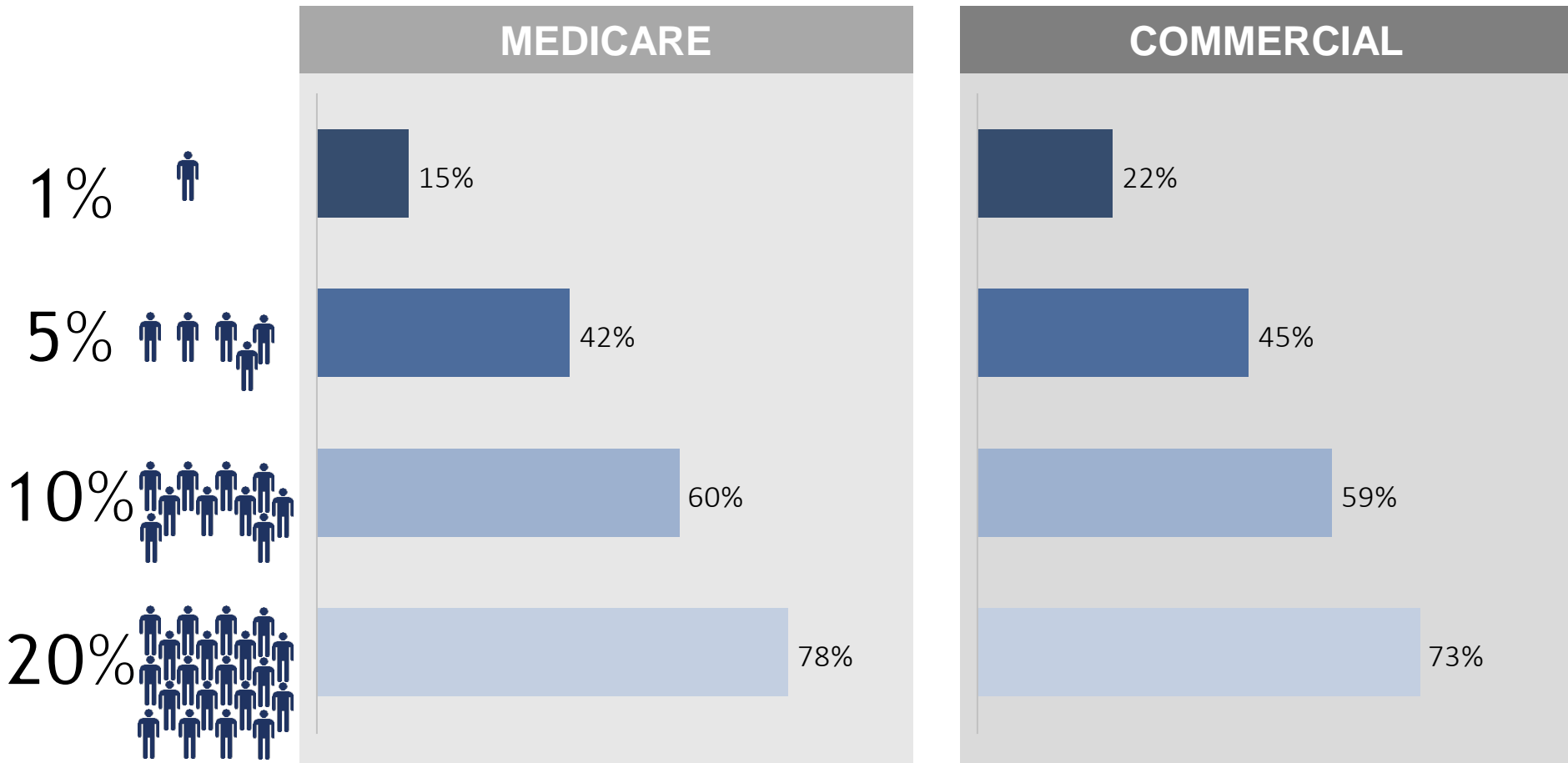
New findings in 2014 Report

- Patients with high total medical spending for three consecutive years represent an important group to understand.
- Results reinforced a focus on behavioral health and managing chronic conditions.

Small subgroup of population represents large proportion of spending among Medicare and commercial populations

Spending concentration in Massachusetts

Percent of claims-based medical expenditures (excluding pharmacy spending), 2010



Notes: The sample was limited to patients who had at least six months of enrollment in both 2010 and 2011 and costs of at least \$1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or the first half of 2011.

Source: All-Payer Claims Database; HPC analysis

Previous findings from 2013 Report & 2014 Supplement

- Patients with behavioral health conditions spend more for medical conditions particularly if both mental health and substance use disorders are present.

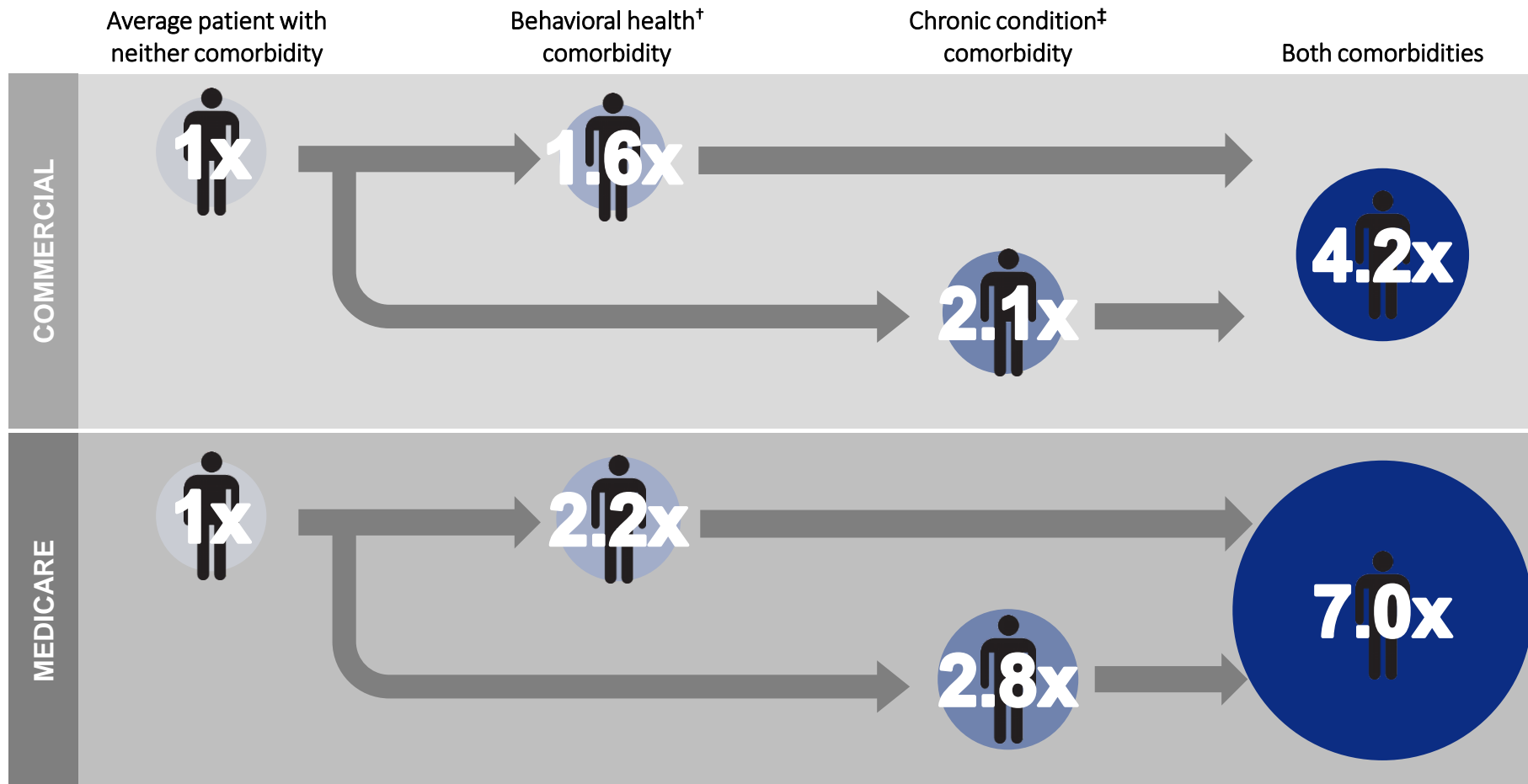
New findings in 2014 Report

- HPC research identifies spending differentials between patients with and without behavioral health conditions for specific medical conditions.
- Addressing current data challenges is essential for the success of any state strategy on behavioral health.

Patients with behavioral health and chronic conditions have significantly higher medical expenditures

Medical expenditures per patient (excludes drug spending)*

Relative to average patient with no behavioral health or chronic comorbidity in 2010



* The sample for analysis was limited to patients who had continuous enrollment from 1/1/2010 – 12/31/2011 and costs of at least \$1 in each year. Figures do not capture pharmacy costs, payments outside the claims system, Medicare cost-sharing, or end-of-life care for patients who died in 2010 or 2011.

† Behavioral health comorbidity includes child psychology, severe and persistent mental illness, mental health, psychiatry, and substance abuse

‡ Chronic condition includes arthritis, epilepsy, glaucoma, hemophilia, sickle-cell anemia, heart disease, HIV/AIDS, hyperlipidemia, hypertension, multiple sclerosis, renal, asthma, and diabetes

Source: All-Payer Claims Database; HPC analysis

Alternative payment methods

Previous findings

- Alternative payment methods offer incentives that support value and reward providers for delivering high-quality care.

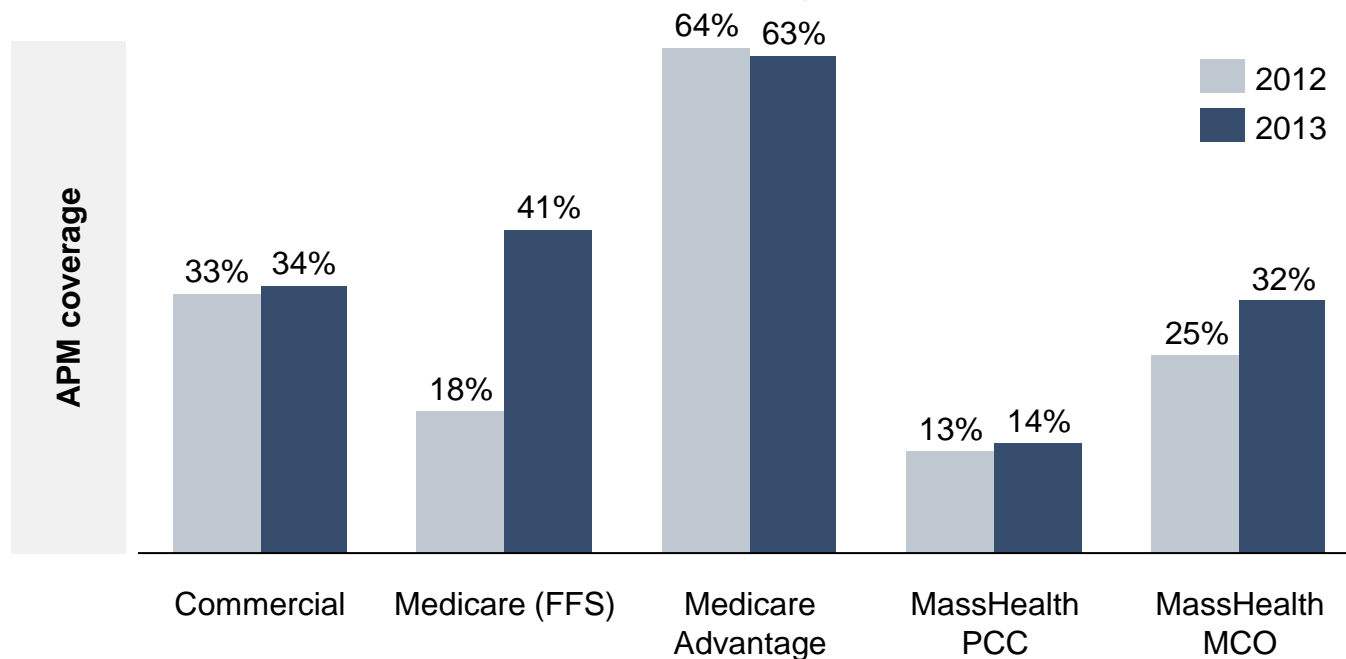
New findings

- The percentage of Massachusetts residents covered by APMs increased from 29 percent in 2012 to 35 percent in 2013.
- With strong payer and provider efforts in three specific areas, APMs could cover 55 percent of members in 2016.
- There are many other opportunities exist to expand APM coverage and strengthen implementation.

Between 2012 and 2013, APM coverage was stable in the commercial sector, but grew in traditional Medicare and in MassHealth MCOs

APMs

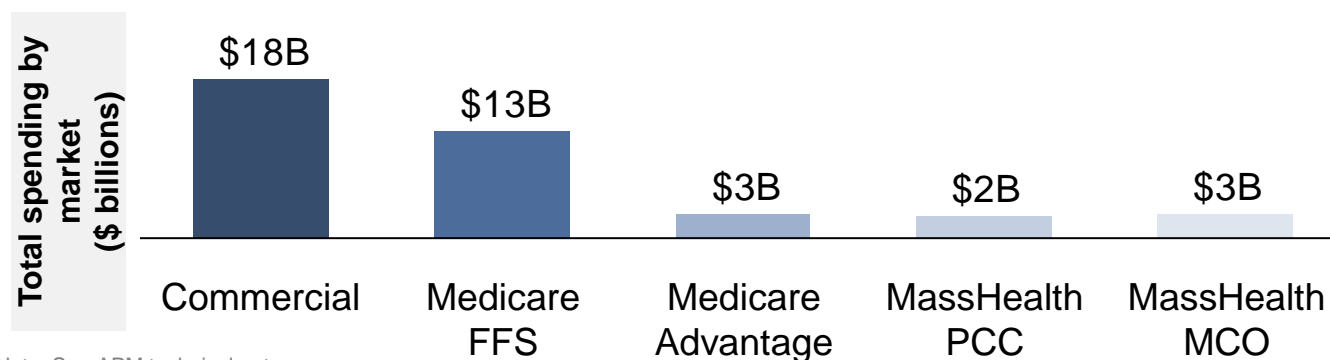
Percent of members covered under an APM, 2012 versus 2013



Total
APM coverage
was

35%
in 2013

29%
in 2012



Note: See APM technical notes.

Source: Center for Health Information and Analysis 2014 Annual Report Alternative Payment Methods Data Book, 2013; Center for Health Information and Analysis 2013 Alternative Payment Methods Baseline Report Data Appendix, 2012; Centers for Medicare & Medicaid Services Shared Savings Program Performance Year 1 Results; Other publicly-available Centers for Medicare & Medicaid Services data; MassHealth personal communication

Demand-side incentives

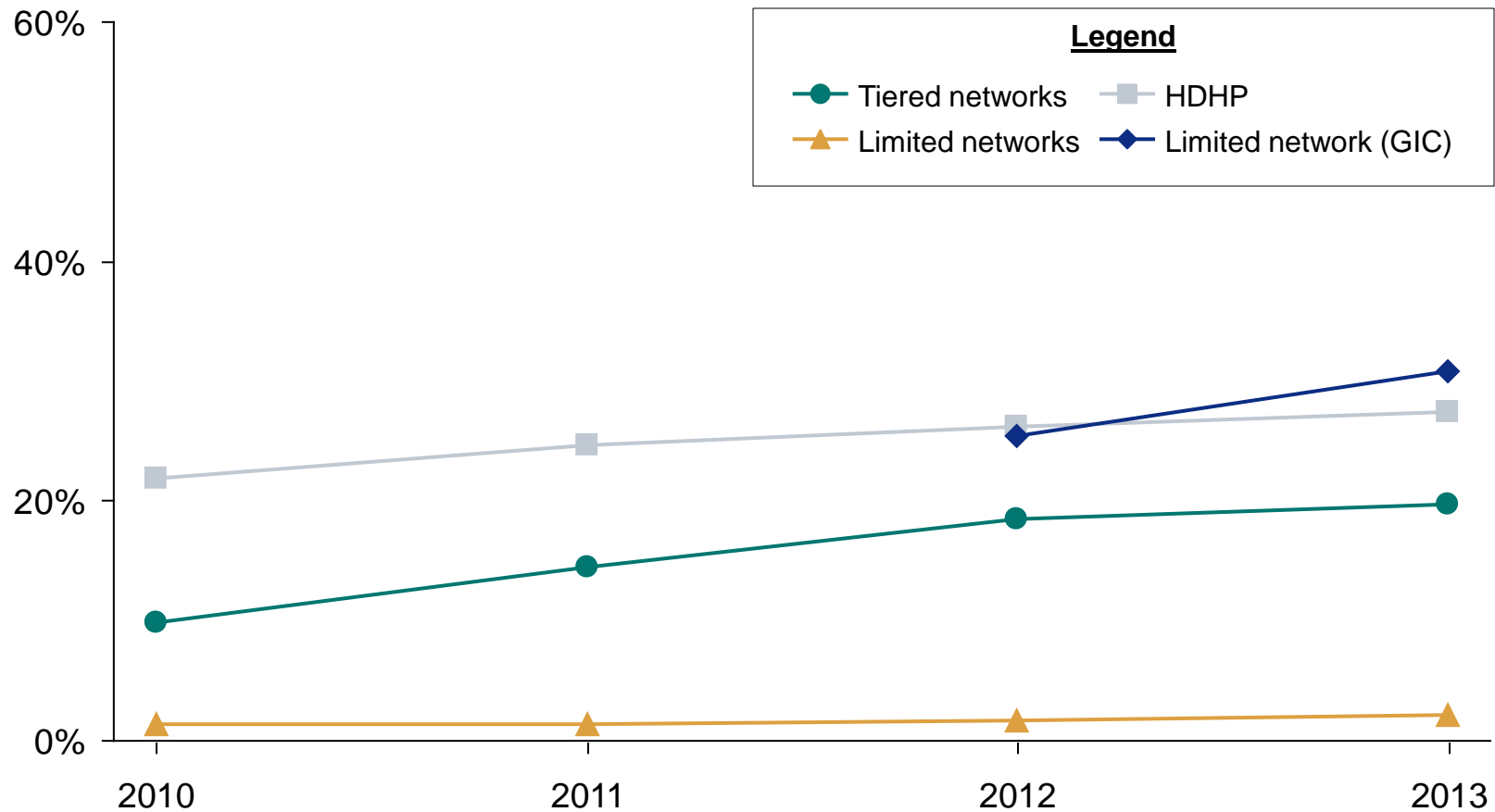
Findings

- Well-designed insurance products offer incentives to employers and consumers to support value and patient-centered care, e.g.
 - Lower co-payments for high-value services
 - Reference pricing
 - Tiered and limited networks
- Adoption of limited network products is low in fully-insured commercial markets, but substantial in the GIC, which offers wide plan choice and quality information for employees.
- Chapter 224 required payers and providers to publish price information for consumers – continued progress is needed.

Enrollment in tiered network and high-deductible plans is growing slowly in the fully-insured commercial market. Enrollment in limited network plans is very low, but high within the GIC

Demand-side incentives

Percentage adoption by network type across all commercial payers and GIC, 2010 - 2013



*Tiered network product as defined by payer. Some variation may exist in included product lines, for instance, between products with hospital tiering versus Primary Care Physician (PCP)/specialist tiering only (included for Harvard Pilgrim Health Care (HPHC)). Blue Cross Blue Shield (BCBS) and Tufts Health Plan (THP) did not include Group Insurance Commission (GIC) members in commercial tiered product enrollment. Aetna includes Designated Provider Organization (DPO) in tiered network enrollment.

Note: Enrollment in THP limited network products does not include enrollment in commercial GIC limited network products

Source: Pre-filed Testimony submitted to the HPC for the 2014 Cost Trends Hearings

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Foundational investments in system transformation

Assessment Distribution

100% = \$225 million over four years

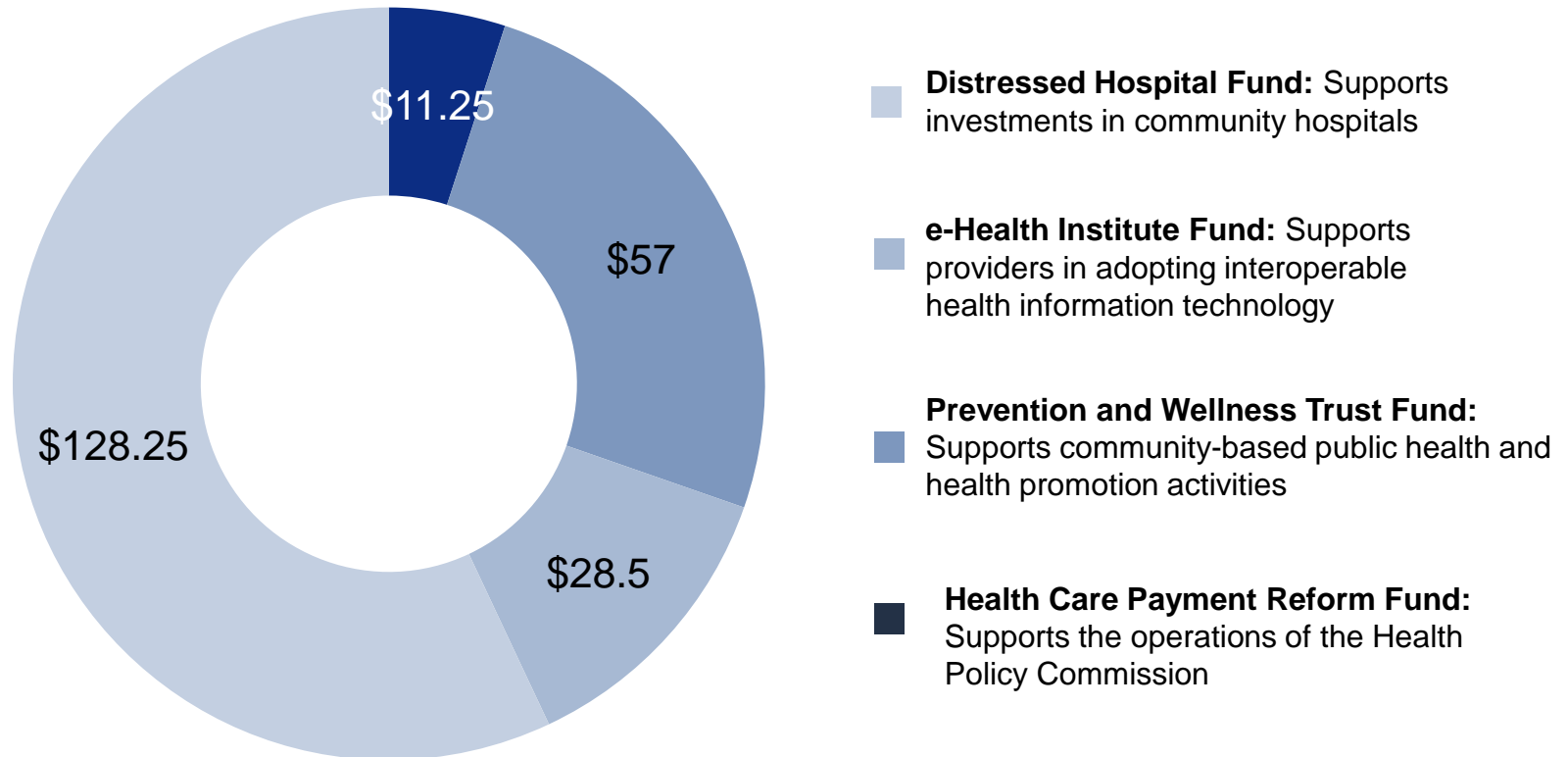


CHART: Community Hospital Acceleration, Revitalization, and Transformation

Overview of CHART Investments

- Funded by the one-time assessment on payers and select providers
- Total amount of \$119.08 million
- Unexpended funds may to be rolled-over to following year and do not revert to General Fund
- Competitive proposal process to receive funds
- Strict eligibility criteria: ~25-30 eligible community hospitals
 - Non-teaching, non-profit, low relative price

Primary Goals

- Promote efficient, effective, integrated care delivery
- Improve quality and patient safety while reducing costs
- Develop capacity to become an Accountable Care Organization
- Advance adoption of health information technology and the electronic exchange of information between providers
- Increase capacity to bear risk and adopt alternative payment methodologies

Achieve sustainable, scalable interventions that benefit communities

Foundational Investments in System Transformation: CHART

CHART's enabling statute lays out ambitious and broad-reaching goals. The HPC's regulatory process further developed the overarching focus of CHART – effectively supporting achievement of the Triple Aim, including payment reform

Overview of CHART Investments

- Funded by the one-time assessment on payers and select providers
- Total amount of \$119.08 million
 - \$128.25M, less \$9.17M provided in mitigation to qualifying acute hospitals
- Unexpended funds may to be rolled-over to following year and do not revert to General Fund
- Competitive proposal process to receive funds
- Strict eligibility criteria: ~25-30 eligible community hospitals
 - Non-teaching, non-profit, low relative price

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Foundational Investments in System Transformation: CHART

CHART Phase 1 awardees span the Commonwealth

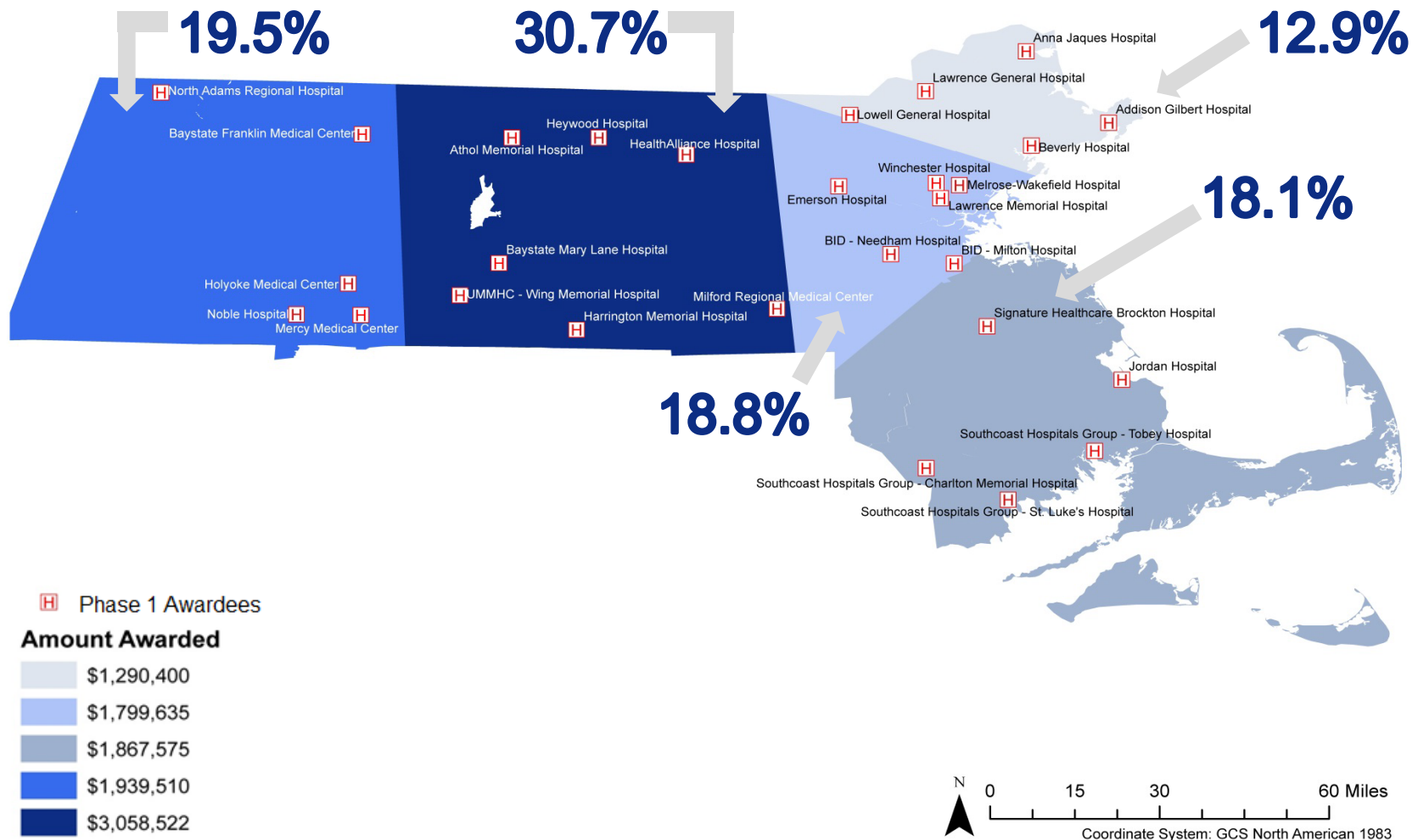
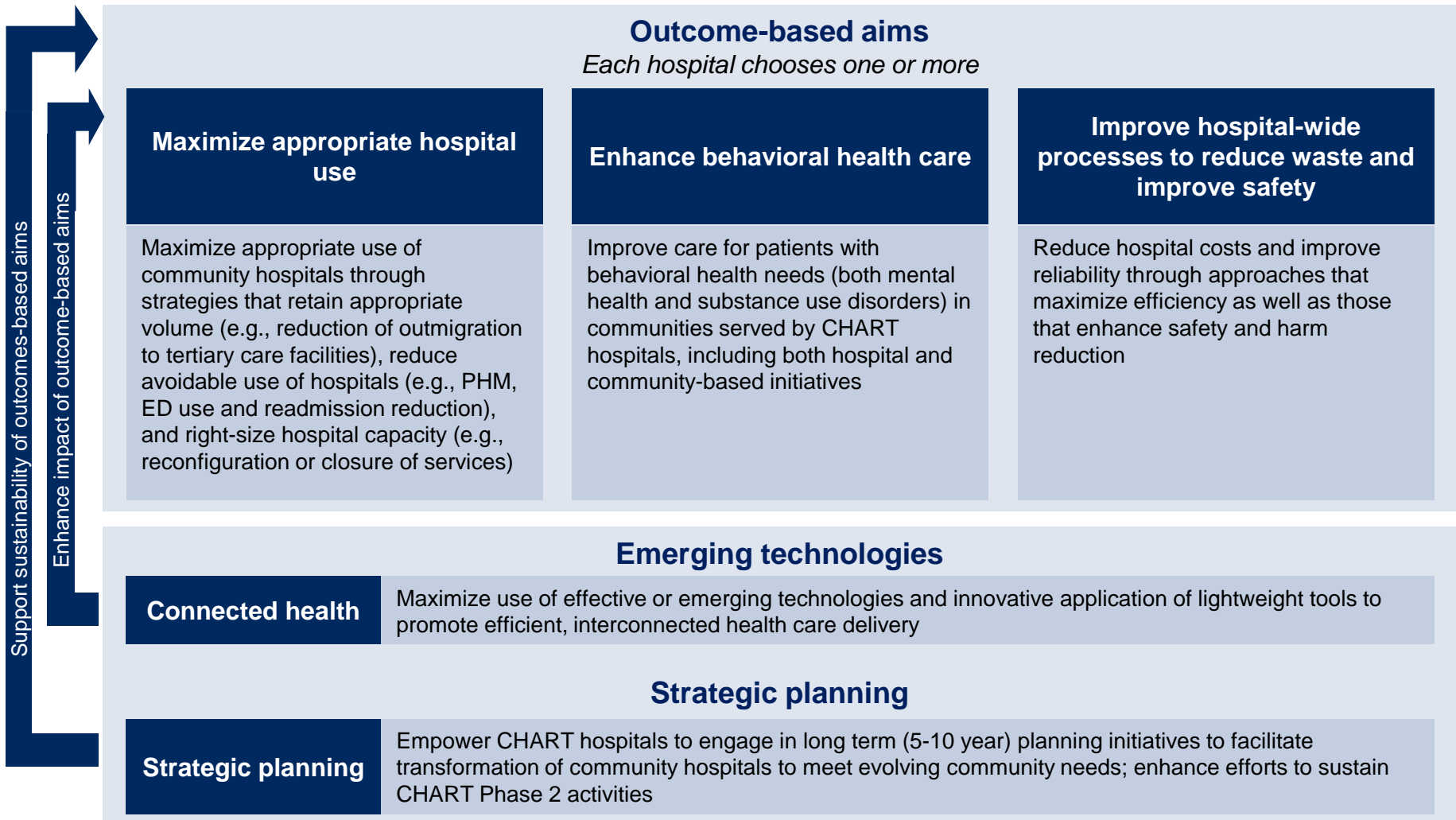


CHART Phase 2

In Phase 2, hospitals propose mechanisms to meet specified aims, with the overarching goal to drive transformation toward accountable care

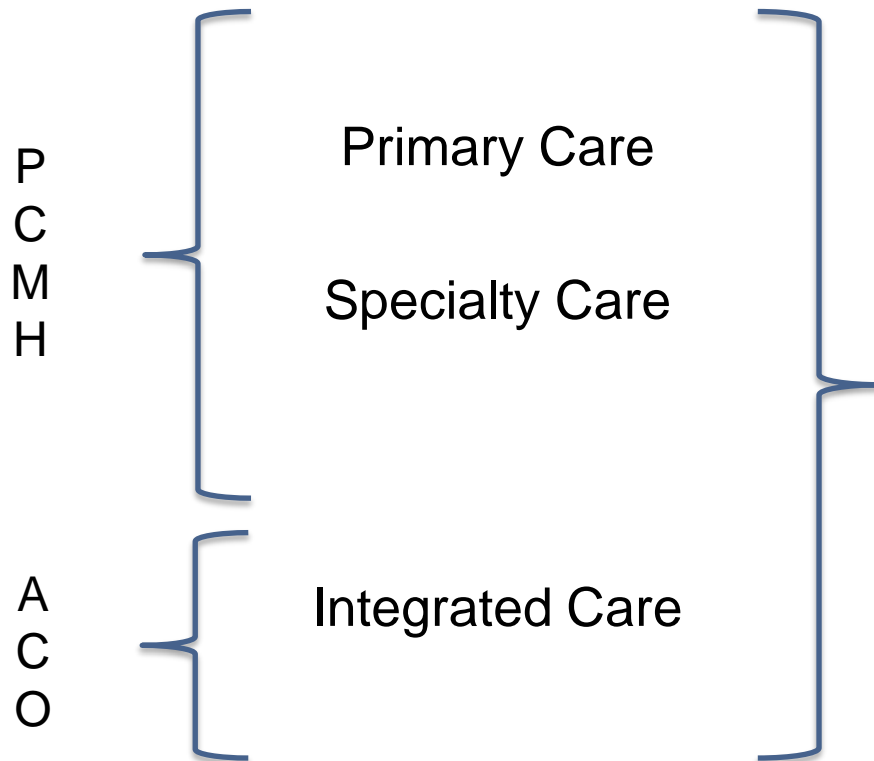


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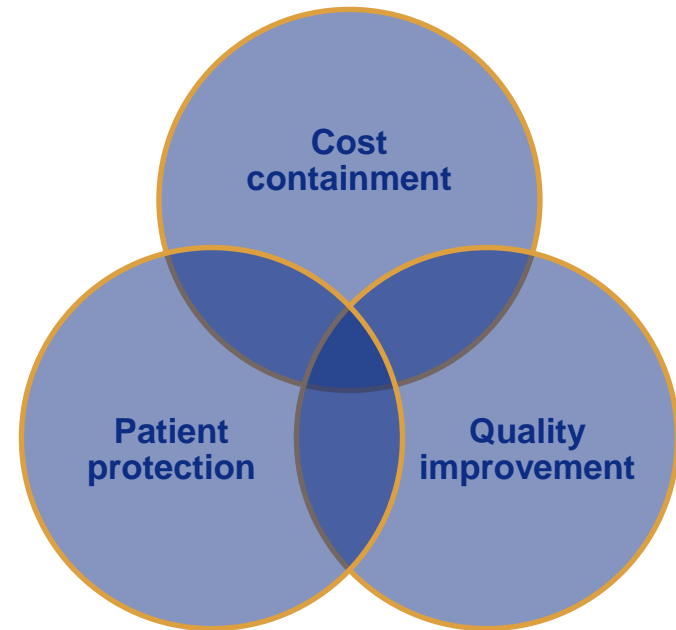
HPC PMCH/ACO Certification: *Patient-Centered Accountable Care*



Accountable Care Certification

A unified framework for promoting, validating and monitoring the adoption and impact of accountable care in the Commonwealth

Ch. 224 links ACO certification to 3 overarching priorities, and specifies 15 related sub-goals that certification criteria should incentivize



- (1) Reduce growth of health status adjusted **total expenses**
- (2) Improve **quality** of health services using **standardized measures**
- (3) Ensure **access** across care continuum
- (4) Promote **APMs & incentives** to drive quality & care coordination
- (5) Improve **primary care** services
- (6) Improve access for **vulnerable populations**
- (7) Promote **integration of BH services** into primary care
- (8) Promote **patient-centeredness**
- (9) Promote **HIT** uptake
- (10) Promote demonstration of **care coordination & disease mgmt.**
- (11) Promote **protocols for provider integration**
- (12) Promote **community based wellness** programs
- (13) Promote health of **children**
- (14) Promote **worker training** programs
- (15) Adopt **governance structure standards**, including those related to financial COI & transparency

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Overview of cost and market impact reviews

- 1 Provider changes, including consolidations and alignments, have been shown to impact health care system performance and total medical spending
- 2 Chapter 224 directs the HPC to track “material change[s] to [the] operations or governance structure” of provider organizations and to engage in a more comprehensive review of transactions anticipated to have a significant impact on health care costs or market functioning
- 3 CMIRs promote transparency and accountability in engaging in market changes, and encourage market participants to minimize negative impacts and enhance positive outcomes of any given material change

30-day quantitative analysis

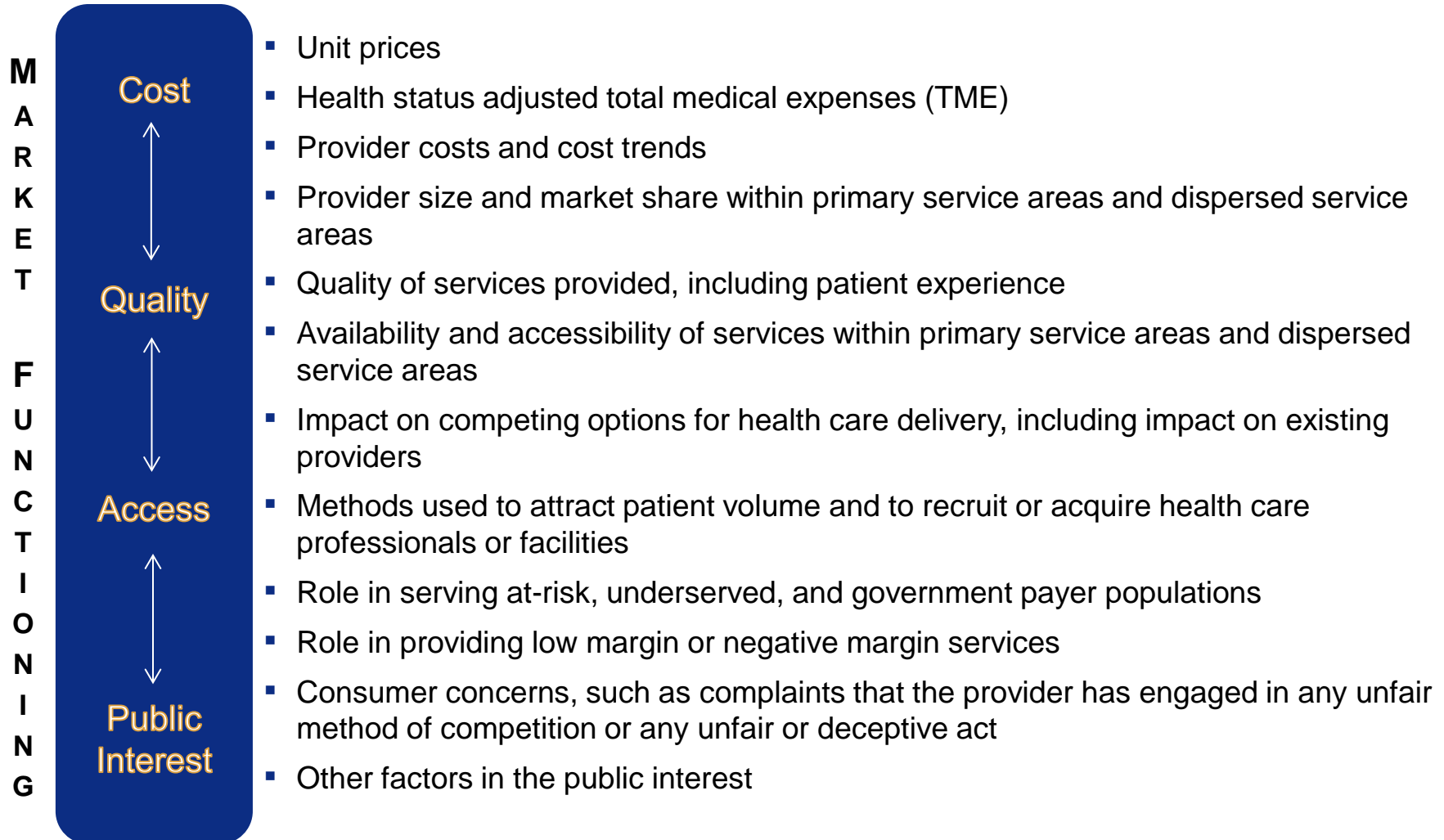
	Costs	Quality	Access
What do we know from the terms of the transaction?	<ul style="list-style-type: none"> Will contractual prices change as a result of the transaction? Will care shift to lower or higher priced providers? 	<ul style="list-style-type: none"> What are the identified areas for quality improvement? What changes do the Parties propose to address these areas? 	<ul style="list-style-type: none"> Are any changes in services identified? How do these changes affect any shortages or oversupply of services?
How will provider and market structure change?	<ul style="list-style-type: none"> Will market share or concentration increase or decrease? What is the anticipated impact on bargaining leverage? 	<ul style="list-style-type: none"> How are the parties aligning incentives? Does the proposed structure support greater clinical integration and population care management? 	<ul style="list-style-type: none"> Will the resulting organization have higher or lower government payer mix? Higher or lower mix of low/negative margin services?
Ongoing evaluation of the parties' goals and plans	Continued evaluation with additional data, production, and interchange with parties and market participants.		

Types of transactions noticed

April 2013 to Present

Type of Transaction	Number of Transactions	Frequency
Physician group affiliation or acquisition	11	33%
Acute hospital merger or acquisition	7	21%
Clinical affiliation	4	12%
Formation of contracting entity	4	12%
Acquisition of post-acute provider	3	9%
Change in ownership or merger of owned entities	3	9%
Affiliation between a provider and a carrier	1	3%

Statutory factors for evaluating cost and market impact



Recent proposed acquisitions by Partners Health Care

- Partners Health Care is the largest provider system in Massachusetts, with eight general acute care hospitals in five regions of the state. It negotiates contracts on behalf of approximately 5,500 physicians. Partners also owns a network of psychiatric hospitals, rehabilitation facilities, and home care facilities.
- Partners receives nearly one-third of statewide payments to acute hospitals and approximately one-quarter of statewide payments to physician groups. Partners' hospitals and physicians generally have the highest prices in their region.
- In 2013, Partners proposed to acquire three more community hospitals (South Shore Hospital and Hallmark Health System's two hospitals) and a large physician practice (Harbor Medical Associates).

Review of proposed acquisitions by Partners Health Care found significant cost and market impacts

- The HPC conducted CMIRs of these proposed acquisitions and found that increases in spending were anticipated to exceed potential savings from care delivery reforms and population health management.
 - The HPC projected that the acquisitions would increase total medical spending by up to \$49 million per year as a result of increased prices and shifts in care to higher-priced Partners facilities.
 - The HPC also found that the resulting consolidated system was anticipated to have increased ability and incentives to leverage higher prices and other favorable contract terms in negotiations with payers (*bargaining leverage*), the costs of which were not included in the above projection.
 - The parties to these transactions did not provide adequate evidence of how corporate ownership was instrumental to achieving the desired care delivery reforms, and their own experience and that of other providers offered compelling alternative approaches to effectively coordinating care delivery.

The Attorney General took the HPC's findings into account in negotiating a settlement agreement with Partners

- The initial proposed settlement between the Attorney General and Partners allowed Partners to acquire the three community hospitals and physician practice, but imposed time-limited conduct remedies such as price caps, caps on growth in total medical expenses (TME) for Partners' commercial risk business, and component contracting restrictions.
- After the HPC released its Final CMIR Report on the proposed Hallmark acquisition, then-Attorney General Martha Coakley pushed Partners to mitigate the price impact of this transaction, one of the concerns identified in the CMIR report, and the Attorney General and Partners subsequently filed an amended settlement.
- During its review of both the initial and amended settlements, the court invited public comments. More than 100 individuals and organizations (including the HPC) submitted public comments either in support of or in opposition to the settlement.
- Common concerns with the settlement included:
 - that it would not mitigate all projected cost impacts;
 - inferiority of conduct remedies over structural relief;
 - complexity of the conduct remedies;
 - time-limited nature of the restrictions; and
 - difficulty ensuring compliance by the parties.

The court cited the HPC's comments as particularly invaluable in its decision to reject the settlement

- During the court's review of the settlement, the HPC provided important factual context for the court through its public reports and its two public comments.
- Newly-elected Attorney General Maura Healey referenced the HPC's public comments in her January 26th Notice of Position to the court, which noted her concerns with the settlement. She indicated that she would enforce the settlement if approved, but would litigate to enjoin Partners' acquisition of South Shore Hospital if the settlement was rejected and Partners pursued the acquisition.
- Judge Sanders issued her 48-page decision rejecting the settlement just three days later, in which she cited the HPC 58 times. In particular, she emphasized that she considered the comments from the HPC the "most important" of all the public comments, and found the HPC's input "particularly invaluable."

Contact Information

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